

DEDICATION OF BARTLETT HALL
MASSACHUSETTS GENERAL HOSPITAL

This day marks the third occasion at which we in nursing have had an opportunity to express publicly our appreciation for this residence. Our thanks come today from the students and graduates who will live in Bartlett Hall, and from all the other students and graduates who will share the facilities from time to time, or rejoice with its occupants.

If appreciation could be considered commensurate with wanting, our feeling would be apparent to all. The history of nursing at the Massachusetts General Hospital has recorded over and over again, for more than forty years, our need of adequate residence facilities. In 1914 while Miss Sara Parsons was the Superintendent of Nurses the Walcott House was opened; a residence which was written up in nursing literature as an example of modern housing for nurses. But in 1916 history tells us again that our houses are inadequate. In 1923 Miss Sally Johnson, Superintendent and Principal of the School of Nursing records the addition of the fifth floor to the Walcott House. But in 1925 reports again state that the nurses' homes are insufficient if the School of Nursing is to be expanded. Over these same years facilities outside of the Hospital grounds were renovated and put into use temporarily. Sometimes for a few years, and sometimes, like our Charles Street Houses, for over forty years.

The plans for Bartlett Hall were begun almost ten years ago before Miss Johnson's retirement. Although laid aside many times to wait until money and building materials could be available, the dreams for such a hall as this have never been forgotten.

The MGH Department of Nursing has two great obligations. One, to provide the best possible nursing care for the patients who come to MGH, and second, to provide the conditions which will enable those who study and nurse here to give

their best. In 1882 when Thayer was built it was expected that any young woman, dedicating some years of her life to nursing, would be a spartan character. For in Thayer there was no heat in the bedrooms, and there were no springs on the beds.

To look at Bartlett Hall is to be convinced that hospitals as well as young women have changed. For the purpose of a nurses' residence today is to provide, not beds and chairs, but opportunities to live graciously.

Bartlett Hall will accommodate 154 students and graduates and a Residence Director. Sixty-six of the rooms, three floors, have now been set apart for staff nurses. Eighty-eight of the rooms, four floors, are reserved for senior student nurses. The first floor as you can see houses the more formal social rooms, and has also the suite for the residence head. The top floor has the lounge inside, and a large porch outside. The bedrooms are arranged in three and four room suites each with bath. On each bedroom floor is a small sitting room, with a kitchenette and laundry. But you must see all these for yourself to see the planning for quiet to provide opportunity for rest and study; the planning of facilities to encourage orderly living and working; the planning of rooms to provide for group activities which encourage responsibility and the consideration of others; and the planning for a home in which girls and young women can find satisfaction and happiness together.

Today we have 385 students in the School of Nursing, and 58 affiliating students who have come from other schools for study and experience with us here. There are 346 graduate nurses employed, 105 of whom live in the several residences. Over 50% of these will now live in Bartlett Hall.

It has been said "One can never pay in gratitude; one can only pay in kind somewhere else in life." These young women can never, and we should never expect them to, repay the generosity and thoughtfulness which have gone into this building. But it is our hope that as they move into Bartlett Hall, sharing the

experience of being the first to discover its joys, they will resolve to pass on to the other students and graduate nurses who come to MGH some of their satisfactions of being a part of this great institution which, though large indeed, does not forget the individuals who study and serve within its walls.

RS:BF

BRIEF REPORT TO THE MGH GRADUATES
AT THE SAN FRANCISCO MEETING

Greetings to each one of you! I wish very much that even for these few minutes in the morning I could be with you to personally say hello, and to hear about you first-hand. Unfortunately, California is too far away for an annual trip, even though the Conventions are interesting and of great value.

Perhaps first you would like to know what our thoughts are on the future of our School. Today, with the Position Paper from the American Nurses' Association and with the increasing trend into colleges, there has been much consideration of what we should do to insure the future of the School. I think you would like to know that the enrollment still holds up and that the quality of applicants is still maintained at the same good level as in the past. If anything, this year we are having a higher average in the College Board Examinations than we had last year, and yet last year's entering class has proved itself an excellent one.

The Faculty, the Hospital Administration, the Advisory Council to the School of Nursing, and the Trustees, have all considered the question of the School's future. *A small but farseeing ad hoc committee of alumni was also called together* It is not possible of course for us to join with a college and so maintain the MGH School name. Therefore, whatever we decide to do must be done in terms of the complete giving up of the School, or in some evolving plan to maintain it as a good school, keeping progress with the times. At the present time the decision has been made definitely that we shall continue the three-year School until such time as 1) we find a type of program which is preferable, 2) the supply of applicants diminishes, or 3) (especially important) the quality of the applicants is lowered. We are still exploring ways and

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means of improving the present program, or of changing it to keep in step with changing times and education. We believe we have too much here in the way of excellent facilities and opportunities of all kinds at the MGH to give up our School.

It is still a problem to find faculty, and we do wish we could have more MGH'ers at home with us, but once the alumna gets away we too often lose touch with her and so do not know who might be interested in a position in teaching.

You will be interested to know that after sixty-five years the affiliation at the Boston Lying-in has been discontinued, or will be by September. The Lying-in which already had a tuition charge of \$125.00 planned this fall to add \$240.00 for a maintenance charge. This seemed to us too much to add to the students' already heavy fees, and so after much deliberation and conferring with the Lying-in we are transferring our students to the Boston City Hospital. The students will live at home and will have advantages in many ways not possible at the Lying-in, for here at the City Hospital we can send our own teachers; we can now work out the School plan to integrate or coordinate or correlate, whatever it may be, the maternity experience with the experience in pediatrics. We shall not have them under one direction but the two Chairmen will I know work closely together for each is hoping to develop an over-all unit in maternal-child which will be effective and challenging to the students.

This year both the special program (the experimental program with Northeastern for our three-year School) and the program for college graduates, originally started with Radcliffe College, will be phased out. The Northeastern affiliation

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we shall not try to replace at the present time, but we do still hope for some kind of college program for college graduates which will use the facilities of the MGH. We have not given up our efforts in this direction, even though the present program will disappear. It has been a fine program, sound and forward-looking, and has turned out a small but well prepared group of young women, many of whom are still in nursing, some of whom have gone on for advanced preparation, and of all of whom MGH can be proud.

The three-year School averages about three hundred and fifty students during the year, but coming to the Hospital also for experience or for affiliation are the McLean students, approximately twenty-five; the Simmons College students, approximately thirty; and the Northeastern students in varying numbers depending upon whether they come for experience as a part of their program with their own faculty or as cooperative working students as members of our nursing service. We also have graduate nurses from Boston University in the spring in Supervision and Administration, and about seventy practical nurse students from two different schools, one private school and one State operated school for practical nurses. Our facilities at the moment are therefore being quite well used and we hope that the future will enable us to contribute this way at the Hospital to education, for we believe the MGH has much to offer.

From the nursing service point of view life is extremely busy. We are getting ready for Medicare amongst other things. A Transfer Unit, set up under the direction of Social Service with cooperation from nursing, and employing two full-time nurses, has been surveying and evaluating nursing homes to see which extended facilities could best serve our patients. The number of aged patients in the Hospital has been high in the General Hospital for some time, and now appears to be climbing rather higher in spite of the fact that the reservations

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Staff Education is studying the ways and means of revising its program, better to serve all groups who come to us, and with some consideration this year of the graduate group from the baccalaureate programs. We do not yet get the graduates of the associate degree programs because they are not active particularly in this area, but I am sure that the time will come when we shall need consideration for this group too, with its special needs.

Our experiment in housing for graduates in subsidized apartments in Charles River Park and one small group of apartments out at Coolidge Corner in Brookline has been a success. We are in fact adding twenty-three more at the moment which will accommodate forty-six nurses, and hope very shortly that we shall need and be able to add still further to the number. This will give us about one hundred and seventy-eight nurses in these apartments. Time will soon tell us whether the plan has had anything to do with stabilizing the nursing staff, or whether it has just made a more comfortable and happy living situation for a limited period of time. It was our hope of course that it would do both.

The North Building proceeds but slowly because we do not see the building going up as it is rather hidden from our usual area of visibility, but it is progressing. As you know this will be a special services building; operating rooms, various kinds of therapy, laboratories, extension of the X-Ray, etc.

The Hospital Trustees have just now voted to add a small unit in the vicinity of old Ward I, but not requiring the demolition of I, for the treatment of the alcoholic. We have had a growing and very successful program in this area

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If I were with you I know I could add much to this, but I am sending just these few top topics as a way of saying to you that the MGH is progressing as fast as ever, that we have more staff nurses now than we have ever had before, that we opened forty-six beds this year without great difficulty, that although we do not know what will happen in another year, we hope we can meet the needs of the patients and cooperate with the other services, Medical, Social Service, Dietary, and all, to the end that the patient care improves each year.

You will remember that the Hospital had three purposes as originally defined in the Charter, now one hundred and fifty-five years ago. The first was patient care, and this I think the Hospital Administration and Trustees as well as nursing and other departments never allow themselves to forget. The second was education and this too is an area of activity considered extremely important and well supported. And then last - research. Nursing is coming slowly along in this field, but we do see it as an area in which we should be more active, and I am quite sure the future will make us so. In other words, our eyes are on the future and our love looks to the past, including all who have come through the School of Nursing or who have worked at the Hospital and who have developed as its graduates a kind of lasting loyalty.

Best wishes for 1966-1967. Perhaps next year I can see some of you in New York when NLN has its Convention.

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Director of the School of Nursing
and Nursing Service

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RS:W

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Dear Seniors:

What next? What will you do when you don your black band?
What role will you play? How will you see your responsibilities?

So much is being said and written about the nurse today. Who is a professional nurse? Are nurses fulfilling their obligations? You and I have talked about this. You saw, I hope, the graduate of the diploma program playing a vital role in nursing and in community health. Now you will find as you start out in staff nursing that you will form the very core of the community's nursing service. Being a professional is not only a matter of education. It is fundamentally an attitude, and you yourself will make the decision as to what your status is to be. One author expresses my thinking as follows, "I am truly a professional man in proportion as I use whatever talents and training I may have, not just to give men what at the time they happen to want, but what, so far as I can discover, they really need."

How well this can apply to your future role: thinking for the mind that is sick; seeing for the eyes that are dim; walking for those whose legs are useless; but giving back independence and joy of self-direction when minds and eyes and legs are ready. It will be a changing world in which you live and work, and your role tomorrow will differ from your role next year. The role tomorrow must include the doer who must also be the thinker, the nurse whose preparation continues on keeping pace with change, the professional worker according as others are served.

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Dear Doctor:

For this exciting future with its new responsibilities and joys, the best of wishes from us all, your Faculty, the Nursing Service Administration, your M.G.H. family.

Ruth Sleeper

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joy, the best of wishes from us all, your family, the Nursing Service
Administrators, your N.O.H. family.

With respect

MASSACHUSETTS GENERAL HOSPITAL SCHOOL OF NURSING

CONVOCATION, OCTOBER 14, 1964

REPORT TO THE SCHOOL OF MISS RUTH SLEEPER, DIRECTOR

Convocation, the calling together of faculty and students in a school or college, normally follows soon after the opening of a school year. Its purpose varies with institutions. The program may be a backward look with the hope that events of the past may provide direction for the future. This we might well do tonight if I had so prepared, for the history that permeates all action at the M.G.H. and its several programs holds wise guidance. Convocation may also be planned to give a sense of unity to the School as a whole or to furnish stimulation for joint effort to meet the challenges which lie ahead. This too would be suitable for my discussion, had I decided to use this approach.

Instead, it seemed to me time for all of us to think about the health agency, the School, and the program we represent. So I have selected as my theme tonight "what a student nurse should know about the M.G.H." As I watch the changes in the Hospital and see you in relation to these changes I cannot but wonder whether you catch a similar picture and what part you see Nursing and Nursing Education playing in this vast complex.

Let us look at the School first. One of two of the original three Nightingale Schools remaining, our School with the Bellevue Hospital School of Nursing in New York celebrates its ninety first birthday on November first. Although the original name of the first independent School, the Boston Training School, was used for the first twenty-three years, the School organization continued uninterrupted when the Hospital assumed control in 1896. Today there are 1,128 schools of nursing in the United States, 870 conducted, like ours, by hospitals, 80 by junior colleges and 170 by colleges or universities. Unlike other types of schools, nursing schools have tended to remain small. In fact our school today with an enrollment of three hundred and seventy-eight is one of the eighteen largest schools in the country.

Size does not necessarily indicate excellence. It can generate activity. In July six students were admitted to the Coordinated Program. On September 10th of this year one hundred juniors were advanced to senior standing, and this progress marked by a new and tall cap. On September 11th one hundred seniors were graduated. In fact six members of the Coordinated Program had already received their diplomas on September 3rd. The total graduates for the year were, therefore, one hundred and six. On September 15th one hundred and twenty-three freshmen were enrolled. Now it is with pride we watch the graduates of 1964 returning to assume important positions as staff nurses in the patient units, the recovery room, and the operating rooms.

The purposes of our parent Hospital will not be new to any of you now; patient care, teaching, and research. To fulfill in part this function of teaching our School was founded. Today we have three instructional staffs, interlocking in planning and in certain common areas of activity, but setting goals and developing programs quite independently to fit the particular group for which the instructors are employed. For example, there has been an average enrollment this past year in the Coordinated Program of fourteen, in the Alternate Program of forty-six, and in the Standard Program of three hundred and ten. To teach you all, there are fifty-one and a half full-time instructors, and one half-time, twelve additional staff members including librarian, health supervisor, supervisor of residences and residence heads. There is a secretarial staff of seven, a total of seventy-one and a half people to plan and implement your programs. Or, we could say one instructor of staff member to every five plus students.

You will see from this that a school of nursing is today a costly venture. A study made in 1932 by a Boston firm of accountants showed as the program was then organized that the School after all charges were paid netted the Hospital some \$100,000.00 per year. The School was then a financial asset.

Today our School budget is well over \$900,000.00 - approaching one million. Also each student graduated now costs the Hospital, after all credit is given for tuition and fees paid, and for contribution to patient care, close to \$4,000 or for a graduating class of one hundred nurses, \$400,000.00.

You and I should both question this cost and study the value of the School to the Hospital. For unless the return is high because many graduates of our School return such expenditure of hospital monies could scarcely be justified.

What does the School mean to the Hospital? Let us look backward for a moment. In 1941 as the Second World War began, the Hospital had an average total of three hundred and fourteen graduates on its staff - these included teachers, supervisors, head nurses and staff nurses, most of which latter were in the Baker Memorial and Phillips House. During the war this number dropped to one hundred and ninety-eight, most of whom except in the Phillips House were head nurses and supervisors and teachers. In 1951, the number had risen to three hundred and thirty-seven; in 1961 to four hundred and fifty-nine. The first eleven months of this year just past we had a daily average of four hundred and nine staff nurses alone, to which must be added one hundred and forty-four administrative staff in Nursing Service, and forty-eight nurse teachers, a total of six hundred and one; almost 100% more than twenty-one years ago. War has many influences on Nursing. It stimulates interest in Nursing. It forces new developments to meet the insatiable demands for nurse-power. It creates uneasiness, desire to move and insatability, all of which retard progress in a service program. Were the M.G.H. to keep the presently employed six hundred and one graduate nurses and add to these as the need for nurse power grows, there would be no problem. Rather each year sees constant change. In 1963-64, two hundred and forty-four staff nurses resigned so that actually to gain in our employment we must now make up our loss of two hundred and forty-four nurses and then seek to add the needed extra. When you look at the graduate nurse staff on the ward, keep in your mind what it means to an institution such as this to have

not only three hundred and seventy M.G.H. students who are in the process of learning to nurse, and approximately ninety others from Simmons College, McLean, and soon Northeastern, but also well over two hundred nurses each year from more than one hundred other different schools of nursing who must be oriented to a new hospital and a different medical and nursing care program.

And all of this goes on while patients continue to come to our doors in larger numbers. The years 1941 and 1951 show little difference in total patient demand for care, a slight increase in private patients, a decrease in the number of patients coming to the service units, White and Bulfinch. There were, however, over 16,900 patients who came for care and the daily average number in the Hospital ranged in these two years from seven hundred and forty to six hundred and thirteen. 1961 shows the changing community need. Almost 9,000 more people came for help, bringing the daily number under our care to eight hundred and thirty-three, more than two hundred higher than that of 1951. Suffice it to say that the year 1964 saw even more.

And so the Hospital's need for graduate nurses in part to fill the posts vacated by nurses already employed, in part to supply added staff for the ever growing number of patients with their increasingly complex care. And to find these graduates is why the Hospital continues to conduct a School.

I wonder if you do realize the detail which grows almost day by day on the patient units. So many steps are added to what might be a simple process in the care of one patient when nine hundred patients and six hundred nurses must be safeguarded. Take for example the administration of medicines. Years ago the medicine card system was devised and seemed a wise and efficient tool. It was used in all hospitals. Stop now to consider what this system means in an institution like this where the number of medicines given daily has increased beyond belief. On Baker Memorial 5 on one day this summer between 7:30 - 3 p.m.,

a seven and a half hour span, 1,134 medicine cards were ruled, sorted, counted, checked, and hunted when misplaced or lost. These are of course not 1,134 different cards, but there must have been over two hundred which were different, perhaps more. I do not have that figure. There were one hundred and seventy-two cards handled at 7:30 a.m.; one hundred and forty at 8:00 o'clock, three hundred and eighty-four at 8:30, fourteen at 9:00; forty-one at 10:00, thirty-nine between 10:30 and 11:00, forty-eight at 11:30; fifty-six at 12:00, one hundred and sixty-eight at 12:15, sixty-six at 2 p.m. and four at 3:00. Total 1,134. Small wonder that the Nursing Service turned to this area of activity when offered opportunity to study the possibilities of help from a computer. Obvious too that when a nurse fails to place a medicine card in the right slot a patient's medicine can be missed for several doses. Remember 1,134 were handled in seven and a half hours and this did not include the busy evening period or the night.

For over a year now a computer research group including first one nurse and now two have been studying by what means the computer could be used to simplify such a process for nurses. We realize of course that nursing can never be mechanized but much that is done in preparing for patient care, much that involves records and many non-patient care activities can be changed. This for nursing is a challenge to fulfil the M.G.H.'s third purpose: 1) patient care; 2) teaching; 3) research.

What should a student know about her School and Hospital, its contributions to nursing nationally, in the State and in Boston? Scarcely a day goes by that someone from School or Service is not at a meeting, whether it be a National Committee on Historical Materials at the National League for Nursing in New York or a meeting of the American Hospital Association's Committee on Research in Chicago, or conducting a meeting of District V Nurses Association of the

Massachusetts Nurses Association, or going to the Boston Nursing Council of the United Community Services, or the Advisory Committee for the new Northeastern University School of Nursing here in Boston. All of these time consuming, all to be added to the daily work to be done at home. Why is all this done?

Nursing we believe is a profession. To those who enter Nursing are granted the rights and privileges of membership in the health team, and these rights and privileges are to be respected and cherished. Upon the professional nurse also fall the responsibilities of this membership. This is no time now to review the criteria of a profession. All except the Freshmen will already know these and the Freshmen and I shall soon review them together. But there are two criteria accepted for all professional people which are basic to the action of nurses at the M.G.H. (1) "Professions . . . are self-organized, with activities, duties, and responsibilities which completely engage their participants and develop group consciousness" and (2) "They (professions) are likely to be more responsive to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievement of social ends."

You, if you will, can not only match the activities of the graduates, you can find the same joy in action. Corresponding to your S.N.C.A. at the moment is no graduate group - but beginning with your district Student Nurse Association - District #V; with your State Student Nurse Association - Massachusetts Nurses Association; with your National Student Nurse Association - American Nurses Association; with your International Student Nurse Association - International Council of Nurses.

Miss Havens has discussed some of the opportunities which can open new vistas for you. I would emphasize the values, the satisfactions which come from active participation in these groups and others with goals of equal value.

What a student nurse should know is far beyond what I could even list tonight. But this is not the point. The important thing is that you search for this knowledge, you join with others in both search and use, and that you learn if you do not already know, not only what to get as a student, but what to give. If this lesson is well learned you need have no concern ever for a challenging and happy life as student or graduate.

RS:BF
10-13-64

As a citizen of the Commonwealth, I come to this first Convocation of the School of Nursing at the University of Massachusetts with great pride. As a member of the Nursing Profession, I come, too, with a deep sense of responsibility for what this School can mean to the citizens of our State, who seek through the better education of the nurse the opportunity for healthier, happier, and more productive lives.

The topic chosen for this paper also indicates this feeling of responsibility in the faculty selected for the School, and serves further to emphasize my own feeling. The topic is The Relationship of Collegiate Nursing Education to Improved Patient Care. Surely, only a positive and fertile relationship will justify the School's existence, or the citizens' faith that the nurse prepared at the State University will warrant this investment in her education.

The title holds many implications. Apparent are the facts that nursing education now has a place in the university family; that we know in general, at least, what the program of collegiate education for nursing should include; that there is now, or is evolving, a well defined or generally accepted pattern of care which patients need, and which the health professions are obligated to provide; and last that the product of the Collegiate School of Nursing has some unique contribution to make to this program for patient care.

Since the education for any profession must stem from the needs of those who are to be served, let us turn first to consider "Improved Patient Care." What is it? How does it differ from the care provided fifteen, twenty-five, or fifty years ago? Within the lifetime of many of us here today great changes have occurred in the total plan for the health care of individuals in our communities. There have been the great scientific

discoveries which have opened unforeseen doorways to life and living in the best sense; the newly discovered drugs; ^{new uses of} x-ray; ^{things new and astonishing} radium; ^{which have not yet actually explored} surgical procedures; ^{and of course the} radio-active substances. There have been new institutions born to increase man's opportunity for productive living, such as the great research units of hospitals and medical schools, or the rehabilitation clinics now being added in many communities. There have been constant improvements in the education of the health personnel who participated in the use of the newly discovered agents, or the work of the newly organized services. And all of this is important, and does improve the patient care beyond the possible imagination of even twenty-five years ago. But still it is not enough!

^{despite the} Improved patient care is more than a plan for giving new drugs, or ^{new} treatments. It is not necessarily the outcome of hospital building programs, or the establishment of forward-looking research institutes. Improved patient care in the final analysis is the result of the services offered by the members of a health team who use their talents, their special training, and all available pertinent resources, to give to every man, woman, and child, sick and well, not just what the individual wants, but what in the combined professional judgment he needs to keep well. It is true that the talents and services of every member of the team are essential. It is also true that when ^{of any member of the team} these services ^{are} given in isolation from those of ^{the} other members of the team, there is a positive contribution. But when these services are applied jointly, and integrated wisely, the contribution, and the duration of the contribution, is greatly increased. A team broadly representative of all pertinent health groups can both interpret the health needs of the individual broadly, and meet them comprehensively. Success, evident when all members of the health team plan and work together for the patient, shows clearly that basic to the successful use of new technological discoveries are the relationships between

the people who use these discoveries for the patient, and the relationships between the health workers and the patient and his family. This is not a new idea, it is as old as group living, but yet this fact is today not given the place of importance it must have, if improved patient care is to be achieved.

And service, whether it be the production of automobiles, or the care of patients, develops because people in the community buy the product. In emphasizing the team of health workers the patient and his family must not be omitted. This means that improved patient care will concomitantly also provide health education. So the man or woman, patient, or member of the family, will increasingly know more about disease and its care, and more about health and its preservation. To say that the wants and needs of such an educated individual should be broadly interpreted, and comprehensively met, is no small order in our time.

Health care by those who share in it at its best is already considered a bargain, ^{can be reduced} not because it costs ~~less~~, but because the money spent in sickness or for health buys so much. The natural sequel follows - sales ^{are up.} During the past seventeen years admissions to hospitals have increased ^{more than double} from 7.7 to 18.9 million, and in this same period, approximately, the increase in Blue Cross subscribers has been over 39 millions, and this represents less than half the number of people covered by voluntary health insurance.

Community demands for public health nursing services have increased ^{steadily} the number so that now all but 13, perhaps fewer, incorporated cities with populations of public health nurses from ~~to~~ in the past ~~years.~~ ^{if} of 10,000 or more have public health nurses.

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Who will give this care? If we look ahead only five to ten years we may find the contributing groups similar to those giving the care today; the doctor, ^sleader of the team, the nurse, the dietitian, the social worker, most frequently; the occupational and physical therapist, often added; the clergyman, also playing an important role. There are ^{may be} others too, but I shall not stop to name them here.

What is to be the place of the nurse in this team? How is nursing to make its contribution to this "Improved Care of the Patient" when the graduates of this School take their places in the community? What will be their unique contributions? Will the contribution be in terms of more nurses, more nursing, or more comprehensive care?

Obviously every school wishes for sufficient enrollment to make more nurses, for numbers are needed. This audience does not need to be told that the demand of the growing population promises to absorb the foreseeable increase in numbers of nurses for the next several years without allowing any appreciable gain over the present ratio of nurses to population. So numbers are important. But ^{numbers alone would be} hardly sufficient to require the establishment of a ^{new} school within this University.

It would appear on first glance that hospitals and health agencies could only have more nursing if more nurses were produced. ^{in our countries schools} But if we look about us in hospitals today we find auxiliary groups; practical nurses, aides, attendants, sometimes equal in numbers to the nurses, sometimes several times greater than the number of nurses. So nursing of a kind can be carried on without great increase in numbers of nurses.

The question is, of course, what kind of nursing ^{can be given without a staff of all nurses} ~~is this~~, and is it what we want for "Improved Patient Care"? Or, is it right to have a part of the patient care given by auxiliary workers, if the nurse plays the proper role in that care? If so, what is to be her role?

It might perhaps be easier to answer these questions if there were an accepted and clear definition of nursing, and of ^{the word} ~~the~~ nurse, to differentiate what the nurse should do and should be from all other workers who assist with nursing care.

^{few years} A ~~short~~ time ago a representative group of nurses with Doctor Esther Lucile Brown worked out the following definition of the nurse: "It is the opinion of this group that in the latter half of the Twentieth Century, the professional nurse will be one who recognizes, and understands the fundamental (health) needs of a person sick and well, and who knows how these needs can best be met. She will possess a body of scientific nursing knowledge which is based upon, and keeps pace with, general scientific achievement, and she will be able to apply this knowledge in meeting the nursing needs of a person and a community. She must possess that kind of discriminative judgment which will enable her to recognize those activities which fall within the area of professional nursing, and those activities which have been identified with the fields of other professional or non-professional groups.

She must be able to exert leadership in at least four different ways: (1) in making her unique contribution to the preventative and remedial aspects of illness; (2) in improving those nursing skills already in existence, and developing new nursing skills; (3) in teaching and supervising other nurses, and auxiliary workers; and (4) in cooperating with other profession in

planning for positive health on community, state, national, and international levels."

What now should and could be the role of such a nurse? Must we have great numbers of such nurses to secure improvement in patient care? Must she do all of the direct care for patients, or if we could have a reasonable supply of such nurses might we secure the necessary volume and quality of services through more effective use of auxiliary personnel? Most of us today would concede that the nurse need not perform all of the services for the patient, but we do see her role definitely as that of the person who sees that the patient has all of these services, and that they are properly performed.

Now, how do we prepare a nurse who can, and will, meet all of the requirements stated or implied in this definition? Even the familiar phrases in the definition take on new connotations when viewed with the forward perspective of half a century.

Can a school of nursing in a university such as this provide opportunity for its students to secure the necessary body of scientific and nursing knowledge, so that upon graduation they will think as nurses - ^{for} this is the reason actually for the student's enrollment in the school? Can the school further provide the impetus which will make the graduate willing to assume the responsibilities which will face her in her time? ^{For without this she will not use her} Will this beginning stimulate purpose which puts professional responsibility higher than just ^{skills with maximum effect} earning a living? ^{Can she keep a proper balance between self interest + prof responsibility?} Will the impetus for personal responsibility for learning gained in the college carry into life, to help the nurse draw maximum benefits from the education to be found in all experience? ^{For that will be necessary if she is to grow both in knowledge + in contribution as the medical science grows} Will the school prepare

community minded citizens, and leaders, as well as leaders in the nursing care of patients? ^{For nursing is a community service as well as an individual service} Will the breadth of education that the university can provide give the graduate of this school insight into her relationships in life, and with those with whom she lives and works? ^{For this is basic to both professional success in the best sense and to an personal happy life}

If the School of Nursing could do all this what could be its contribution to "Improved Patient Care", or perhaps I should say what could not be its contribution? ^{Professional nurses have} ~~The~~ have for many years ~~in nursing~~ talked about comprehensive nursing care, and we believed every word we uttered on the subject. We wanted the young women entering our profession to practice nursing both as a science, and an art; we wanted them to remember that the nursing of a patient was the care of body, mind, and spirit; we wanted them to see nursing as the care of the well, not only of the sick; and we wanted these future nurses to appreciate the importance of the patient's relationship to his family, and his community. ^{We wanted them to see + use nursing in its best} We wanted them to do comprehensive nursing. ^{to the medical and all the pertinent parts medical groups} We wanted the patient ^{the community} to have the best.

All the time we were working to this end the task before us was growing rapidly - in volume; in variety of demand; in area to be covered. Yet our thinking did not change, for we were convinced of its rightness. But the time came when there was not enough to go around, ^{and this unhappy state continues}

Today, new meaning is coming into our definition - comprehensive nursing comprehensively given - the best still in nursing care for the patient, but now the ^{plan to spread this care to} ~~best for~~ the increasing numbers who need it. This is a challenge for the nurses of today, and will continue to be a challenge when the students here today are graduated. In addition to knowledge of nursing and the ability to work with others to use this knowledge to the best advantage of all people, the nurse must be prepared to improve nursing, and to find ways and means to get this improved nursing to more and more people. Studies, experimentation,

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research, who will do these? The college trained scientist, the nurse with sound background of study, and an investigating mind. At no time in our history have we had greater need for such nurses.

Yes, this School can make a unique contribution, if it will turn out nurses who will see it as their responsibility that the patient gets help, not just in the old pattern but by whatever means are ^{to-day or to-morrow} right, through participation as a respected member of the professional team, through guidance of auxiliary and other co-workers, through investigation into new and imaginative ways to spread the best in nursing to the greatest possible number, through the ability to work and think independently, even while establishing and maintaining good relationships in and with life.

If this contribution is made in the years to come
what a tribute ^{it will be} to the men and women who planned the School and
are making it possible - one more facet in the State's effort to bring
better health care ^{allot} to its citizens, and better education to one
group who will share in the process

STAFF EDUCATION AND ADMINISTRATIVE RESPONSIBILITY
FOR THE BETTER CARE OF THE PATIENT

Staff education and administrative responsibility for the better care of the patient - to nurses familiar with the pattern of the hospital school of nursing, which combines responsibility for patient care and education, such a title should not seem strange. Over the generations nursing service directors have carried also the title of "Director of the School of Nursing", and have succeeded in their plans for nursing care to the degree that the school of nursing under their direction prepares successful nurses. But, in the early days the school of nursing was the nursing service. Then began the gradual evolution of the all graduate nursing service, the graduate service supplemented by students having clinical experience, and finally today, the combination of professional nurse, practical nurse, student nurse, and auxiliary worker.

For the student, the educational emphasis is well founded in a school's curriculum. For the graduate nurse and the auxiliary worker, there is no set pattern, no legal requirements to stimulate planning. Moreover, the graduate nurse is employed as a skilled worker, and the auxiliary worker can be trained quickly for the tasks assigned. Is the nursing service then to conduct an educational program? Is that a function of administration? It would be interesting indeed to have time to search through the old records, to see how the functions of administration in nursing have changed over the years as the pattern of nursing care has become more complex, and the nursing service personnel has been affected by changing social trends and augmented demands of local and national health services.

Nursing administration, as envisaged from early records of hospitals of seventy-five years ago, indicates four areas of responsibility. First, the area which I shall call business. To be sure that early super-

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intendent of nurses would have disclaimed knowledge of budget or hospital accounting. One wonders what her reaction would be to the electric adding machine, or to the I B M machines of today. But she was responsible often for the purchase of food and other supplies. She, too, must have struggled against the handicap of inadequate numbers of personnel, because the money for nursing was limited in amount.

Second, the area which I shall call maintenance. In part this must often have been her responsibility. There were directions to be given to carpenters and painters at times, and such work to be approved. Equipment - beds, tables and chairs, must have needed occasional repair. Linen which had to be washed, had also to be mended, and finally wore out, ready to be torn into bandages.

Third, the area which I shall call organization. In this area she was responsible for developing a pattern within which lines of authority would be known and respected. Although she did not have job specifications written which she could give to workers, doubtless she could name the functions which each worker was to perform. On the whole, the area of organization was simple, for she was responsible to the hospital superintendent, and of the two nurses on each ward the older was usually the head nurse responsible to her.

The fourth area - if she had thought a name necessary, she might have called the area of employee interests. In this area fell many activities which this superintendent of nurses took as a matter of course, as she attempted to build and hold a staff which would function smoothly and effectively. There was the selection of pupil nurses and the other workers for whom she was responsible - the care of the workers who were ill - the talk with the ward tender whose work had gone badly because he had sat up at night with a sick wife - the discussion with the head nurse who never seemed to get on with the

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drug clerk - and the bedside teaching given to the new probationer who had arrived the day before.

How many similarities and differences nursing administration today will show in contrast! The business responsibilities have narrowed to the problem of budget. There are dietary, store, maintenance, purchasing, housekeeping, pharmacy, departments; all to carry the special responsibilities within their designated scope. And so the director of nursing today can turn her attention to those activities through which the nursing service contributes to the better care of the patient. You will notice, I hope, that I omitted to say - "And so the director of nursing has time to turn her attention to nursing responsibilities as a result of this more modern institutional organization." But this is not the case, and so I omitted to say it.

The nursing service of the 1870's and 1880's was a simple, kindly service, involving few workers. Just to realize that there was no thermometer for the very earliest professional nurses, no stethoscope, no blood pressure machine, no hypodermic syringe, no intramuscular syringe, for nurses to use; no X-Ray preparation; no laboratory tests as we know them now; no aseptic technique; no intensive medical research program. Just to realize these differences will speak for the differences between the two systems.

The nursing service of 1950 is a complicated, dynamic service, requiring many workers with many different types of experience, training and skills. In spite of this, there are similarities in the two systems which remain. First, there is the need for an organization structure, in which the lines of authority and responsibility are clear and appropriate, and the need for job specifications to show the worker where his responsibilities lie. There is also need for the area which I have called the area of employee interest, in which employees are considered in relation to problems of personal adjustment, work adjustment, interdepartmental and intradepartmental relation-

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ships, teamwork, health, morale, and work contribution. The superintendent of nurses fifty years ago could know all of her employees personally. She could know the problems which would interfere with their work, and their lacks on the job. And the employees were secure, if she were the right type of leader, in her interest, and in the fact that she would see that they were trained to do their jobs well. Today this area of administration is called personnel administration. It may be the special responsibility of a trained worker, employed by the institution, for part or all of the employees. But the principles of personnel administration are the responsibility of every nurse who directs a nursing service, a division, a ward, or a nursing team. Personnel administration today, as many years ago is the science of the development of people to the end that effective results with people are secured.

To return to the topic of this meeting - staff education and administrative responsibility for the better care of the patient. It is necessary to narrow the discussion to one aspect of personnel administration - the training of workers. Who comprises the staff? When is training indicated? What should be the plan? How can the results be measured?

For purposes of illustration I shall include in the staff any worker who gives service on the floor or ward which assists directly with the care of the patient. I shall have in mind the supervisor, head nurse, the practical nurse, the aide, the orderly, the ward helper, the ward clerk. As I list these it is evident that there is a wide diversity of work represented in the group. There are wide differences in experience, in education, in age, and in interests. As all work together for a common purpose, each must cooperate closely at times with all others. Each must have certain functions for which he has responsibility. Each must understand her own place in the organization. Each must know how her functions fit with, or facilitate, the activities of all others. Each should respect the other worker for her con-

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tribution. Each should grow consistently toward greater effectiveness through her experience. Each should find satisfactions in her relationships with the others and pride in the team's accomplishment, and in her own individual contribution to the team's achievement.

In short, to have good patient care there must be first, informed workers; second, skilled workers; third, good group relationships; fourth, the worker must find satisfaction and pride in his work. Here are the objectives for an in-service or staff education program. The purposes are equally important for all groups of workers. Used as guides to planning, such objectives indicate the need for a separate content for each group, for each group has different functions. There is also need for a common content, since all groups work in the same institution, and work together.

A staff education program divides naturally into three parts. First, the orientation of the new worker. Second, the training of the unskilled or further training of the less adequately prepared worker to meet the needs of the assignment. Third, the continued plan for information and stimulation of the experienced, skilled, worker. Obviously each group will need these three divisions in its program. For example, for the registered nurse there should be an orientation plan to introduce her to the institution; the personnel with whom she is to work; the ward, and its physical plan; the location of supplies; the methods peculiar to the institution in relation to such activities as charting or medications or special equipment or ward routines or unusual treatments. If the nurse is not familiar with the metric system, and it is used in the institution, classes in the metric system would be included as a part of this orientation.

The second aspect of the staff education program for nurses would include the training of the less adequately prepared worker. This may

tribution. Each should grow consistently toward greater effectiveness through her experience. Each should find satisfaction in her relationships with the others and pride in the team's accomplishment, and in her own individual contribution to the team's achievement.

In short, to have good patient care there must be first, informed workers; second, skilled workers; third, good group relationships; fourth, the worker must find satisfaction and pride in his work. Here are the objectives for an in-service or staff education program. The purposes are equally important for all groups of workers. Used as guides in planning, each objective indicates the need for a separate content for each group, for each group has different functions. There is also need for a common content, since all groups work in the same institution, and work together.

A staff education program divides naturally into three parts. First, the orientation of the new worker. Second, the training of the new or skilled or further training of the less adequately prepared worker to meet the needs of the assignment. Third, the continued plan for information and stimulation of the experienced, skilled, worker. Obviously each group will need these three divisions in its program. For example, for the registered nurse there should be an orientation plan to introduce her to the institution; the personnel with whom she is to work; the ward, and its physical plant; the location of supplies; the methods peculiar to the institution in relation to such activities as charting or medication or special equipment or ward routines or unusual treatments. If the nurse is not familiar with the metric system, and it is used in the institution, classes in the metric system would be included as a part of this orientation.

The second aspect of the staff education program for nurses would include the training of the less adequately prepared worker. This may

be necessary for the nurse who has been inactive over a number of years, or a nurse who lacks experience in such situations as she may be required to meet in the particular institution. For example, she may be unfamiliar with chest suction, with the respirator, with certain of the medications, or with the referral plan.

Finally, the skilled nurse who has been a member of the staff for several years may find stimulation and satisfaction in learning about the evolving research program of the institution in which she shares in some small way; or the newest of the medications; or changes in the development of the team plan. She may need also some plan to help her maintain proper relationships with the community health agencies; with the medical staff; with the other departments of the hospital.

When the program for unskilled workers is considered, the situation will differ markedly in some respects. There will be here the worker who has had no previous association with a hospital; who must be oriented, and then trained in even the most simple duties. There will also be those who have worked in hospitals, have even had similar titles, but whose preparation is none-the-less grossly inadequate. They do not possess skill. In this group, too, will be found men and women employed for some years who believe they are and who are called "skilled", because they have been employed for many years. To these latter employees the need for further training may never be evident, yet these like experienced nurses need the stimulation of continued training to hold them to the best level of their performance.

Why, we might say, does this type of educational program make such a difference? Why are not the workers of all types capable of doing their best work without constant instruction? Let us consider here what makes an effective worker, and what makes him continue to be an effective worker?

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Why, we might say, does this type of educational program make such

a difference? Why are not the workers of all types capable of doing their best work without constant instruction? Let us consider here what makes an effective worker, and what makes him continue to be an effective worker?

First, to be effective, one must know how to do the job. Second, one must want to do the job well; week by week, year by year, as long as the individual is employed. He must not grow stale, or complacent, complacent in relation to the job or to the level of performance on the job, or to the amount of work accomplished. Third, she must have a continuing sense of accomplishment. Fourth, she must have a feeling of satisfaction in the work. Fifth, she needs above all, to know that her job is important to the success of the project as a whole. Sixth, the individual must find the right relationships between her daily work and the life outside the job.

Without a plan for in-service education some individuals can find some of these factors for themselves. Most individuals have the capacity to find but few, and so their work, their care of the patient, is not geared to the level of their best performance. The nursing service, therefore, which aims toward the improvement of nursing care, must include in its program a plan for staff education. Or, the nursing service as an employing agency is obligated to furnish an in-service program, just as it is obligated to look after the health and general welfare of its workers. In a large institution this necessitates many programs - the director plans for the assistant administrators and supervisors - the assistant administrator plans for the head nurses - the supervisors and head nurses plan for the staff nurses. A special supervisor may be assigned full time to the lay personnel, the aides, the orderlies, the ward helpers, the maids and ward clerks. Or supervisor and head nurse may plan for any one of these groups. There is no set pattern. The size of the institution, the numbers and preparation of the staff, the allocation of functions, will determine the possibilities. The important factor is that there is a plan. For the institution which provides no systematic plan for this in-service, haphazard and misdirected teaching will be used to fill the need, and the results of such a plan are apt to be frustra-

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tion, unhappiness, and poor patient care. There is nothing mysterious about an in-service education program. As in any plan for instruction or teaching the principles of education apply. There must be the selection of the purpose; the choice of the teaching content to accomplish the purpose; the adaptation of method to the group, the situation, and the desired outcomes.

Two new factors, or perhaps I should say two factors not always given proper emphasis are participation of the employee in the program planning for his group, and second, the emphasis on personnel relations or human relations. It sounds strange as I write these words "human relations" to think that nurses whose lives have been spent working to care for human beings should have need to discuss human relations. But we have many characteristics inherited from our wise and foresighted forebears, and one is the lack of the science of human relations in dealing with our co-workers. In the past the patient was the end and all of the efforts. The worker was important, not as an individual, but as a worker and to the degree to which he or she assisted in the care of the patient. The patient's care is no less important today. There is no less emphasis on that care, but we do know today, in this particular social era, that effective results from people will only be secured if those people have opportunity to develop as people.

When a nursing service considers a broad plan, which sounds new and perhaps a bit radical, someone invariably asks "How much will it cost?" If nursing service could only know how much time and effort is now being wasted because of the lack of such a plan, there would be a satisfactory answer. Obviously, the program in any institution cannot be the responsibility of any one person. If the institution is a small one and the staff is prepared and can add to its existing load, the plan may be put into effect without additional personnel provided. The director, or her assistant, can give the proper leadership to the other participants. If the institution is large, several new

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supervisors may be needed. However, the savings in personnel turn-over, the reduced absenteeism, the reduced wastage of supplies and hours, the improvement in the spirit of the workers has in the past shown that the product of the worker is of improved quality. So we might well say that the improvement of the care of the patient may more than compensate for the added salaries.

This previous statement sounds as if I offer in-service education as the panacea for all the ills of shortage and poor work. It should be emphasized again, that in-service education is but one phase of a sound personnel administration program. It is the program as a whole, of course, which counts, and every institution should today have a sound personnel administration program. But the participation of the employees in planning an in-service education program will serve to strengthen the personnel administration program as a whole, for representatives of each group who help to plan for their group will bring to the administration of the nursing service needs and problems which will be of use in improving the employees health program, the plan for selection of employees, suggestions for improving working conditions (and I do not refer here just to pay). All those factors which assist in the maintenance or establishment of good group or institutional morale, the catalytic agent which turns knowledge and skill into effective patient care.

It is not possible to tell a director of nursing service just how to organize her particular program. It is not possible to adopt the program of one institution and put it into effect as is in another institution. The purpose of an in-service program is to enable the auxiliary worker and the nurse in a specific institution to give the best possible care to the particular group of patients under circumstances peculiar to that one institution. Ideas from reports of general planning from other institutions

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are helpful. The knowledge that other institutions can introduce a program is stimulating. To hear the struggles of another nursing service director against group disinterest, or lack of participation, helps to relieve frustrations at home. But each institution must have its own program fitted to its own particular personnel and their specific needs in their situation.

REPORT ON THE DEVELOPMENT OF
A BASIC PROGRAM IN NURSING

The evolution of the hospital school of nursing begins in the United States with the opening of the first three schools under the Nightingale Plan in 1873. Established as they were to provide care for the sick and a new vocation for women these schools over the years have reflected trends in medical practice and problems of hospital economics. But only within the past few years has the reflection of educational trends been clearly evident in the organization and curriculum of the hospital school.

The first schools were established as independent schools which secured the use of hospital facilities for nursing practice. As the value of the student nurse was demonstrated, hospitals in increasing numbers established schools. As a large majority of these hospitals were privately controlled, voluntary hospitals, a system of nursing education was established under which the voluntary hospital assumed a major responsibility for the preparation of nurses for the country as a whole.

The first schools offered little formal instruction. The accepted method of teaching was the apprenticeship method. The students with the matron or superintendent of nurses constituted the nursing staff of the hospital. Experience was restricted to whatever care the institution offered to its patients, and whatever ancillary services were needed to give this care. The program was usually two years in length; one year of training, one of nursing. The student was paid and in fact was considered as an employee of the hospital.

Wherever there were well conducted schools, hospital care of patients tended to improve, medical practice was facilitated, and nursing care was obtained at low cost. The good school soon expanded its program. With

the hope that a longer period of training might mean a richer experience the two year plan was extended to three years. Special experience in executive work and district nursing were added. Students were sent to assist in the operating room. Some were given assignments in the special therapeutic diet kitchen. A few hospitals even began to consider affiliations in obstetrics, when that clinical service was not available in the home hospital.

Much of this progress was due to the efforts of the Society of Superintendents of Training Schools for Nurses of the United States and Canada*, a voluntary, national nursing organization, established to assist with the sound development of training schools. Under the stimulus of the program of this organization student personnel policies began to improve. The eight hour day was tried. One school gave a medical examination on entrance. Monetary allowances to students were discontinued by schools which hoped with added money to improve instruction. Tuition was charged by some. A few schools as early as 1900 required entering students to have 12 years of general education. Graduate head nurses (ward sisters) were employed, bringing at once a release of students from this responsibility, and a new form of supervision on the ward. The first class room was especially equipped for the teaching of nursing.

In 1899 the first college preparation for nurse instructors was offered at Teachers College, Columbia University. Full time teachers were thereafter available. In 1901 the preparatory (preclinical) course was introduced in which students, freed from nursing service responsibility, studied and practiced under close supervision for 6 months before they were fully accepted into the school. An educational pattern for the hospital school had begun to take form.

*In 1912 this organization became the National League of Nursing Education

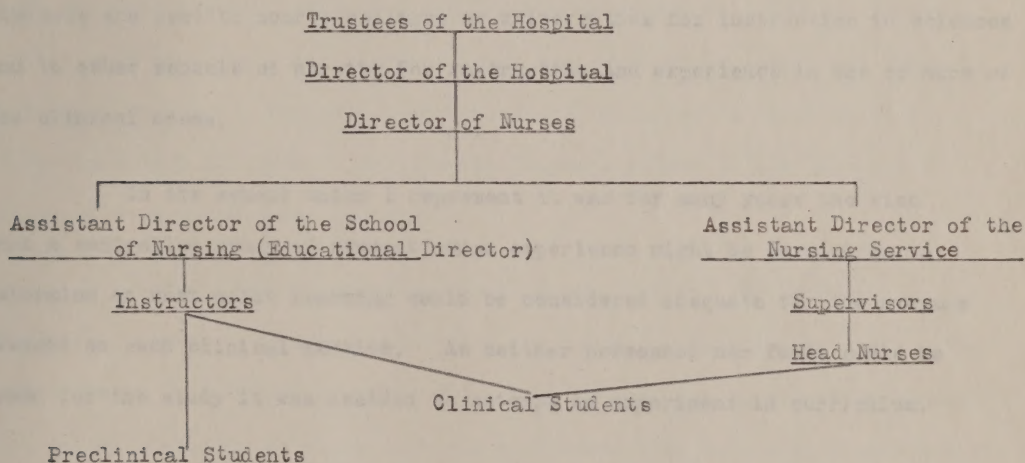
In 1917 the National League of Nursing Education focused attention on curriculum development as a faculty responsibility by publication of "The Standard Curriculum". Through the years of the 1920's the major emphasis seemed to be on the improvement in teaching of the physical and biological sciences as the basis for better understanding of the principles underlying nursing and the medical sciences. With the publication of "The Curriculum" by the National League of Nursing Education in 1927 emphasis was extended to include the social sciences. But it was not until the organization brought out a "Curriculum Guide" in 1937 that schools began to include sufficient social science to give a sound basis for the nurse's understanding and effective care of the patient and his family.

Only now has the hospital school begun to grasp the importance of the study and application of the principles of interpersonal relationships in nursing. Only today does the school begin to see how the team concept can open up new avenues for improving nursing care and education for better patient care.

As there was no control over schools of nursing for approximately thirty years, schools were started wherever nursing services were needed. By 1900 there were 432. By 1920, 1755. In 1929 there were 2,205 of which 1/3 had a student body of 22 or less. Obviously both good and poor features have been associated with such uncontrolled growth. The poorly equipped and inadequately staffed schools appear to have retarded the development of sound systems of nursing education and nursing service. The inadequate graduate is a poor public relations agent. Public knowledge of conditions in the poor schools discouraged recruitment.

The first organized attempt to close the poor schools was made by the Committee on the Grading of Nursing Schools in 1934. The second by the National Committee for the Improvement of Nursing Services in 1950*. In 1952 there are 1150 schools remaining.

The typical good hospital school of nursing today is conducted by the voluntary, general hospital. It is approved by the state and accredited by the National Nursing Accrediting Service**. The school is controlled and financed by the hospital. It is administered by a nurse appointed by the board of directors of the hospital. A common example of the organization of a school of nursing and its relationship to the hospital nursing service is as follows:



The larger the school, the more complex the organization grows. The director of nurses carries responsibility for both care of patients and education of nurses. In a small institution this dual responsibility will be assigned also to assistant, supervisors, and head nurses. In a large institution completely separate staffs may exist for the patient care and the

*A committee of the 6 National Nursing Organizations. Functions under the sponsorship of the National League of Nursing Education.

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educational program. In the former instance the instructors from the school, the supervisors and head nurses plan together for the students' clinical experience, and share both formal class and planned ward teaching. The student in this pattern is part of the ward staff during the ward experience. In the latter instance the instructors may make and carry out the plan as a whole, following the student from class room to ward during her entire experience. Under this plan the students supplement the graduate nurse staff which carries the responsibility for the patient care.

Students pay for their education in large part through services given to patients, a questionable practice. A small tuition is also customary. In some schools all of the instruction is given in the home school. In others students are sent to nearby colleges or universities for instruction in sciences and to other schools of nursing for instruction and experience in one or more of the clinical areas.

In the school which I represent it was for many years the wish that a controlled study of student nurse experience might be carried on to determine at what point learning could be considered adequate for the average student on each clinical service. As neither personnel nor funds could be found for the study it was decided to attempt an experiment in curriculum.

First, we decided upon the outcomes we hoped to secure. There were six. (1) The graduate of the program should be able to care for any patient admitted to the home hospital. (2) She should have sufficient knowledge of conditions found in the community to enable her to work effectively in other institutions where clinical facilities were different or more inclusive than our own. (3) She should have sufficient knowledge of the community and the families from which her patients came so that she would understand the total care of the patient. (4) She should have a sound basis upon which to build,

if at a later time she wished to continue her studies in nursing.

(5) She should have and know how to maintain her own physical and mental health. (6) She should be ready to accept her responsibilities as a professional woman and a citizen.

Objectives were planned, content, including practice was reviewed, reorganized, or rewritten to meet objectives. All clinical nursing courses were planned to correlate with clinical assignments. For more effective learning, integrated in appropriate courses was the content dealing with pharmacology, nutrition and diet therapy, social and health aspects, mental hygiene and psychosomatic elements, and first aid. To make best use of teaching time classes were planned the year around. To divide the class into smallest possible groups, and to move more groups of students through assignments each year, all teaching after the preclinical period was repeated 4 times each year. The objectives indicated the areas in which clinical experience must be given. Experienced judgment estimated the time to be allotted to each clinical service.

Meanwhile, the committees were hard at work. The curriculum committee worked on course content with the subject matter specialists. The committee on ward teaching coordinating with the curriculum committee planned the special teaching for each clinical assignment both in terms of orientation to new services or new wards, and in terms of problems of nursing care. As students were to be assigned to medical and surgical wards in the first, second and third years, the ward teaching on these services was planned on three different experience levels. Since the actual patient care was to determine the specific elements in the ward teaching content, the plan was patient centered in its emphasis.

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Other committees were active too. Student personnel policies were reviewed. Hours of practice were reduced to make reasonable study possible. The committee on admissions studied admissions procedures and launched a continuing recruitment program. A bulletin describing the program was sent to all secondary schools within a 100-300 mile radius. Pictorial posters were sent to over 4000 secondary schools in the eastern part of the country. Speakers were sent on invitation, often solicited, to secondary schools, civic and social group meetings. School girls, girl scouts and other groups were invited to tour the hospital. Items of interest about the school were sent to local newspapers. The response has been gratifying. Selection of students is possible.

The health committee reviewed and revised the school health policies. Average days lost from illness per student has dropped in the last three years from an average of 7.5 days off from illness to less than 2.5 days.

The counseling program was revised. A full time Counselor was employed. The evaluations committee studied the process of evaluations as a tool for student growth.

The student-faculty relationships committee considered student needs and sent recommendations for more liberal policies to the Student Organization.

The annual loss of students since 1948, when the program was introduced, has ranged from 6% to 11%. The enrollment of students has risen from an annual average of 278 to 359 students.

The pattern of the curriculum is shown in the following.

It is expected that the student during the educational period will reach the level of safe practice. In the internship it is our objective to develop skill, and to orient the student to graduate nursing practice.

The Hospital School of Nursing in Nursing Education

Day by day as I observe the need for nurses, and the care which can be given by the graduates of hospital schools, I am more than ever convinced of the value of the three year school. At the same time, I am equally sure that we, responsible for these schools, must make many changes if our schools are to hold respected places in the country's educational system. Unless this status can be achieved, the hospital school will not continue to attract desirable candidates in sufficient numbers and a new system of preparing our nurses will be found.

The history of the hospital school of nursing as it developed in this country shows the training school in the 1870's to about 1914 as synonymous with the hospital nursing department. The school was the nursing staff for the parent hospital. Education was always, or far too often, a matter of trial and error learning. Until the early 1900's the school was not even dignified by the possession of a full time teacher. Nursing education, if it could be so called, was inexpensive, and so was the nursing service given to patients. Doctors and hospital administrators were apparently not concerned or were content with the care received by their patients, but the intelligent pupil nurse in this situation was troubled for she could recognize patient needs she could not meet; she could see the results of the lack of knowledge and of skill she did not possess; she wished for teaching and supervision the school did not supply; she graduated resolved to work for a system of education which would give more protection to patients and truly to develop the school as an educational unit. The results of the efforts of hundreds of such pupils are obvious today. The diploma schools have grown in number ^{enrolled} and in quality. The collegiate school these women fostered is now an established leader in the system of nursing education. From these collegiate schools with their programs for graduate nurses and undergraduate students in nursing come the administrators, supervisors and teachers for our hospitals and their three year schools.

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These early leaders and their successors have followed certain guiding principles, only a few of which we have time to mention today. First, a school of nursing like any other school should be conducted primarily for the education of students. Second, that education should be growth in knowledge, skills, and attitudes necessary for the work to be done and should be dynamic and ongoing commensurate with the ability of the learner. Third, that the nursing curriculum should include a balance of related theory and practice necessary for sound learning, provide opportunity to develop skills through actual patient care of patients, relate practice to learning by assignments which are selected for learning values. The laboratory or patient care experience grows in value as it provides new and challenging opportunities to learn. Supervision according to the learners' need and a sound plan for evaluation and guidance increases the value of any laboratory practice.

If the school faculty studies the patient's needs, physical, emotional, and spiritual in the hospital and at home in the light of developing medical and social programs, the objectives for the curriculum will obviously be patient centered. As the faculty are guided by accepted methods of teaching and learning, the curriculum will be adapted then to both student and situation in which learning is to take place. The outcome of the ^{such} objectives should be a curriculum in which the student learns, a ^{patient service} ~~and~~ which benefits in so far as is consistent with education from the student practice and finally a supply of graduate nurses who both feel themselves to be and are ready to take on graduate nurse responsibilities.

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of the school's product. Blaming the system of hospital financing does not help. Accusing the NLN of pushing standards of nursing education beyond reasonable limits doesn't help either. Besides it is really not the NLN which is to blame, but the professors of education who have so successfully inculcated in the nurse educators their modern philosophies of education.

Were it not for costs, I doubt the hospital administrator would care what methods the school employed so long as the school produced the desired supply of graduates and was a good school. The nurse director on the other hand, may know little or nothing about the budget for hospital or about the methods through which hospital financing is accomplished. She may wonder why ^{everything} ~~all~~ seems financially possible for the staff, the medical students in the hospital or for the continuous planning for more and more beds. The educational methods she has learned are just as foreign to those ^{administrators} ~~problems~~ as the hospital administrator ^{problems are} ~~may~~ feel in relation to the changing methods of teaching.

So what happens? What should happen? The best in-service education program in the hospital should take place with the same purpose every in-service program should have - to improve the worker on the job. There is the administrator, who wants his school to be a good one. He ^{needs to} ~~listens~~ and learns why the school needs changes in methods and facilities. The school director also ^{needs to} ~~listens~~ and ^{to} ~~doubtless~~ modifying her own reading program meanwhile, ^{in order to} ~~and~~ learning about the methods of hospital administration which affect the school. These learning sessions properly planned might well include the school council or advisory committee who would advise better if they too know both sides. The trustees, the assistants in hospital administration, the department heads may be included and at appropriate times, the medical staff might wisely be involved also. This is the more formal side of the ^{of} ~~the~~ mutually planned in-service education program for hospital administrator and nurse director, but there must also be the informal sessions in the day-by-day contacts.

of the school's program. Planning the system of hospital financing does not help. Assuming the aim of providing standards of nursing education beyond reasonable limits doesn't help either. Besides it is really not the aim which is so plain, but the persistence of education who have no successfully indicated in the nurse educators their modern philosophies of education. We are aware of the fact that we are not for today, I doubt the hospital administrator would care what methods the school employed so long as the school produced the desired supply of graduates and was a good school. The nurse director on the other hand, may know little or nothing about the budget for hospital or about the methods through which hospital financing is accomplished. The way however why the nurse financially possible for the staff, the medical students in the hospital or for the continuing planning for more and more beds. The educational methods she has learned are just as foreign to those problems as the hospital administrator, who is in relation to the changing methods of teaching. The first in-service education program in the hospital should take place with the same purpose every in-service program should have - to improve the worker on the job. There is the administrator, who wants his school to be a good one. He listens and learns why the school needs changes in methods and facilities. The school director also listens and learns why his own methods program needs to be changed about the methods of hospital administration which affect the school. These learning sessions properly planned might well include the school council or advisory committee who would advise better if they too were both sides. The trustees, the assistants in hospital administration, the department heads may be included and at appropriate times, the medical staff might also be involved also. This is the more formal side of the initially planned in-service education program for hospital administrator and nurse director, but there must also be the informal sessions in the day-by-day contacts.

Basic to their success will be the mutual desire to understand why the hospital school must change if it is to remain in the system of education for nursing; why education for nursing will, in fact must, grow in cost; why our hospital schools will fail unless the top administration ^(the hospital administrator) responsible for them can give educated leadership; why the hospital administrators, represented collectively by the A.H.A. and the school director represented collectively by the NLN, must work with understanding and respect for their differences in objectives, program, and approach.

Committees on the improvement of patient care have been established and dissolved because parent organizations did not take seriously enough the problems to be dealt with. To my knowledge, state and local branches of the Hospital Association and the League for Nursing have yet to sit down ^{seriously and continuously} to study the major problems before both organizations and their constituents. National organizations are large and cumbersome for group discussions and problems do have geographic differences. The state and local organizations could provide more intimate discussion of questions and plans closely related to the individual hospital and school. Information, interpretation, analysis, at this level might bring the answers which are too often charged with emotion in the larger groups.

The NLN derives its educational standards, finds its voice and vote in its individual members, your director of nursing, your school instructors. Of necessity, therefore, it often moves slowly. It was organized to make possible the participation of all. The state and local branches depend also on accumulated individual opinions and decisions. How helpful it could be made with intelligent understanding of the problems of the two groups of individual most concerned for the future of the hospital school. So much can be done to experiment wisely or to study the old patterns and to search for new ones which will improve programs and increase enrollment. New patterns of education may not prove costly or difficult. Who knows? Who should find out?

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It would be unfortunate indeed if the hospital directors in their interest in nursing education overlooked the importance of their interest in nursing service. ^{might have} I mentioned earlier the need for clearly defined objectives for the nursing service. ^{When I mentioned the principles and objectives for nursing education. The objectives} These, of course, should be consistent with the hospital's objectives. ^{for nursing service should} They should indicate the standard of care to be achieved, the functions to be performed, the types of ^{paid} workers to be trained and employed, the responsibility of nursing service continuously to study and revise and improve its program. No one really knows yet what possibilities there are for more economical administration and operation of a nursing unit which will, in spite of economy, give good patient care. In the area of nursing service there should be less opportunity for lack of agreement between administrator and nurse director. But each will need to see clearly the importance of the nursing service as separate from the school of nursing and as fundamental to the hospital's patient care program. Interpretation of problems related to staffing will be needed, time saving equipment which is expensive must be justified by actual presentation. There will also be need for interpretation by the hospital administrator who is proficient in the art of administration. He can give much to his nurse director perhaps quite unprepared in this area. Help for her will ultimately reflect in the hospital administration as well as in the nursing department.

Many of us in nursing service have been concerned over the emphasis of the AHA on nursing education and the lack of attention to nursing service problems. We can understand, I believe, your concern over the diminishing contribution of student nurses and the increasing costs of schools of nursing. We can recognize your concern over the lack of graduate nurses for employment. But we cannot understand your lack of concern for the needs of nursing services which are equally and perhaps more acute. A well conducted, lively nursing service with nurses who enjoy their nursing is one of the best public relations agents a hospital can have for its potential patients and for the nurses and the men and



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women in the community seeking jobs. Obviously our shortage is not over. There are probably not enough young woman interested in nursing as a career to supply the need as now seen. The difficulty is we do not sit down together to study our situations in the hospital, or on local, state, or national levels.

Whatever is done for nursing service will strengthen nursing education - a good service makes a good practice field; good methods of patient care provide the foundation for good teaching and learning, happy nurses encourage potential candidates for schools.

Yes, I believe a hospital school is needed in our system of education. But the hospital school of the future will need a new look. There is not too much time to plan for the need is now.

It would be unfortunate indeed if the hospital directors in their interest women in the community seeking jobs. Obviously our shortage is not over. There are many who are interested in the hospital as a career to supply are probably not enough young women interested in nursing as a career to supply the need as now seen. The difficulty is as we get all down together in a study of the situation, we find that the hospital is not a career for the majority of our students in the hospital, or on local, state, or national levels.

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expensive and be justified by actual improvement. There will also be need for improvement of the hospital administration who is proficient in the art of administration. It can give much to the nurse through better supervision.

In this case, the hospital will assist in the hospital administration as well as in the nursing department.

It is to be expected that the hospital will have been concerned over the expense of the hospital administration and the lack of attention to nursing service problems. We are convinced, I believe, that the hospital administration is the key to the improvement of the hospital as a whole. We can improve the hospital as a whole by improving the hospital administration.

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I.C.N. 1899 - U.S. England. Germany -

Now some 59 countries ^{active} { equal rep - National officers + aff't rep - cost-
Board meets annually ^{elected} & major committees
Council - at Congresses

Purpose - standards of patient care

Started - educ - eligibility - of country - State reg-
Organized - self gov. nurses association

Ed. program - meeting
standards - basic +
information on post basic
formerly - admitted all

R.N.'s - now
problem of gener. vs.
specialized.
curriculum study -

Attempt to set nursing
care standards -

country contribute
problem -
colloquialisms in
care

Norway - fish

Beginning switch to
principles -

V. Henderson def
of nursing

Program - Education - Florence Nightingale Inst. Foundation '34

Service - Trust - Assoc I.C.N. 1949 } Consultation
spec. recommend for income

Economic security - nursing & labor

Ethics -

Exchange of nurses -

Assistance to displaced nurses

Unofficial membership in WHO.

Publications - Nurs. Review International Mental Health
Library -

Congress - post war - Atlantic City - Stockholm, Rome, ^{Brazil}
Melbourne - Frankfurt.

TOGETHER WE DID IT

We all knew that the Hospital was facing two dilemmas. Beds had been full for many days and solaria were doubling as patients' rooms. Occupancy over 100% on the adult wards made us all concerned. Perhaps the Hospital could not do its share, either for the patients coming to it daily, or for the large numbers who might come if the community suffered a disaster. Second, there was a deficit in the Hospital's budget. Period reports from the Accounting Department and Department Head conferences had kept the administrative group informed of this, so the Director of Nurses and her Associate in Nursing Service were not really surprised when the Hospital Administration called a conference to discuss the projected deficit for the next five accounting periods. This now was a matter for emergency action. The meeting occurred on Thursday afternoon about two hours before the plane was to leave carrying both Associate and Director of Nursing to the Board of Directors meeting of the National League for Nursing in Chicago. Very quickly it was decided that the Associate Director of Nurses, who had a report due in Chicago the following morning, should go. The Director of Nurses would remain behind for a few days to work out the problem with the nursing staff and the Hospital Administration.

Each Hospital Department in its planning approached the problems in its own way. Some delayed filling current personnel vacancies. All accepted an austerity program, and curtailed orders for supplies. Nursing offered not only to curtail supplies but also to open a floor which had been closed since 1943. Thirty beds had already been opened in the spring, but now the personnel seemed somewhat more stable and another move appeared to be possible.

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possible.

The first step for the Nursing Service was to determine whether the members of the various groups involved would help to work out the experiment. Meetings followed in rapid succession.

Friday morning

The Director of Nurses met again with the Hospital Administrative Committee for further briefing on the over-all situation.

The Assistant Directors of Nursing met with the Director of Nursing to begin planning.

Friday afternoon

The Assistant Directors of Nursing met with their day and evening supervisors to review the staffing situation, and to see from which floors personnel might be taken to staff the newly opening ward.

A notice went to each floor and clinic announcing a series of 4 meetings on Monday for day nurses, and 1 early Tuesday morning for night nurses.

Hospital Administration contacted Housekeeping, Dietary and Pharmacy Departments, Stores, Central Supply and Telephone Services, that they, too, might begin to plan.

Monday morning

At 9:30 the first group of nurses met: staff nurses, head nurses, supervisors, assistant directors, and the teachers from the School of Nursing. Other nurses came to the later meetings as best fitted their schedules; 10, 10:30, and 11:00. While coffee was

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being served the Hospital Comptroller discussed the budgetary situation, and described briefly what other Departments had been asked to do. Then the Director of Nurses and members of each group described what the Nursing Department might do to help. In all the meetings combined almost 300 nurses discussed the problems, gave suggestions for saving time and money, and agreed that together we might be courageous enough to open the floor without waiting to employ additional staff.

Monday noon

The Assistant Directors of Nursing met with the Director to discuss further the assignment of personnel.

At one o'clock the Director of Nurses attended a meeting of interns, residents and chiefs of services, called by the General Director of the Hospital. The problem of adding beds without opportunity to employ added staff, and the areas in which Nursing needed the support of the medical and surgical staffs in this venture were discussed.

Monday afternoon

The meeting with evening staff nurses and supervisors was held at three o'clock.

Tuesday morning

Both Comptroller and Director of Nurses were ready at half past seven to meet with night nurses and supervisors who, as always, had good ideas to help.

A memorandum prepared by the Director of Nurses was sent out to every member of the medical and surgical House staffs, approximately 175. This put in writing the situation as discussed at the

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at the previous day's meeting with them, and included also the suggestions made by the nurses at their meetings. A letter prepared by the Director of Nurses discussing the opening of beds and its affect upon the staffing in other units went to all members of the Hospital Visiting Staff, approximately 600. To this was added a further note signed by the General Director of the Hospital. Enclosed in this letter also was a copy of the memorandum sent to the House Staff.

Tuesday afternoon.

At two o'clock when the Assistant Directors of Nursing came together the selection and reassignment of personnel was ready for the ward to open. An assistant head nurse from the semi-private unit was to be promoted and assigned as head nurse. A staff nurse from gynecology was to be promoted and assigned as assistant head nurse. And so it went - each of the six large units giving, sometimes with considerable sacrifice, one or more of their personnel to staff the new floor. Housekeeping had cleaned the floor, set up the patients' units, and made the beds. Pharmacy had stocked the medicine closet. Stores had brought the general suppliss. Central Supply Room had delivered its essential equipment. Dietary Department had found a maid, and was ready to provide the food service. An Assistant from the Hospital Administration remained on the floor, or nearby, to assist and coordinate activity.

At six o'clock this same day the Director of Nurses left for the Convention, secure in the knowledge that the beds would be ready for occupancy on Wednesday morning. With a lot of planning and little time - together we did it.

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